Mental Hospitals

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PHOTO: PENNA. DEPT. OF COMMERCE

Puppets tell the mental health story at a Pennsylvania Farm Show

In this issue:

THIS MONTH'S COVER

"Life in a State Mental Hospital" was the theme of a puppet play which we presented at a Pennsylvania Farm Show as a part of the Department of Welfare exhibit.

An audience of some forty people—more than could properly hear what was going on—collected whenever this eight-minute play was given. As part of our exhibit we also displayed puppets in various stages of completion, so that members of the public could examine in detail work being done by mental patients. Among the most popular was an effective "state trooper" which was made by a patient on the Admission Service of one of hospitals. She herself had been brought in by a state trooper only two weeks earlier and clearly expressed her feelings about him through the puppet.

Twelve hospitals co-operated in making the puppets, furniture and properties, as a part of their therapeutic program. I coordinated their efforts during my routine visits, and altogether the preparation took somewhat under three months.

The play, which was written in collaboration with a number of state and institutional personnel, uses hand puppets, representing patients and personnel, which were operated by two occupational therapy aides. The play opens with two female patients straightening up their day room. Daisy, a manic patient, provides a light touch of humor throughout, telling the audience that they have funny ideas about patients—patients are human beings and they can read! The second scene shows an occupational therapy shop with a patient making a weaving frame and telling the occupational therapist that he doesn't feel so much like breaking windows when he has a chance to do this kind of work. The third scene, in a laundry, features a working patient talking with her doctor about going home. In the final scene, this patient gets word that she has passed staff and talks with Daisy about her feelings regarding the hospital. The play ends with a bow from the staff, represented by a doctor, nurse, attendant, occupational therapist, occupational therapy aide, psychologist and social worker. The work of many other departments was mentioned in the play.

Since the Farm Show the play has been repeated at a supervisory workshop and again at an Open House in one of our hospitals. The State Office is now considering the use of the puppets and their settings for role-playing with aides and other personnel in the in-service education program. Using puppets rather than people, it is felt, would remove by at least one step the threat posed by role-playing and more spontaneous material might result.

Many children as well as adults were in the Farm Show audiences, and we hope that some of the educational value of the show might have remained with these young future citizens.

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"S.O.R.T. Room" Activities Aid Young Patients

By RENATE T. LIEBMAN, O.T.R.

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Elgin State Hospital, Illinois

In May, 1954, the "S.O.R.T. Room" was opened at Elgin State Hospital. This is the name the children selected for the new combination School-Occupational Therapy-Recreational Therapy Unit. Formerly a marking room, it was converted into a special room for the children by means of washable paints in pastel shades on walls and cabinets, and new tables and desks with plastic tops.

At the present time there are sixteen children in our program, ranging in age from six to seventeen years. Ten of our youngsters are diagnosed as having Schizophrenic Reaction, two as having Personality Trait Disturbance and four as having Chronic Brain Syndrome with Behavioral Reactions. None of the children in this special group are mental defectives.

All activities are geared to children's interests, with academic work in the morning, crafts, sports—indoor and outdoor games—in the afternoon. The whole program is directed towards helping the individual child to work and play satisfactorily with others.

The number of children accessible to the program fluctuates, averaging between 12 and 16 children. Every newly admitted boy or girl under 17 spends several weeks or months in the S.O.R.T. program until such time as he is discharged, transferred to another institution, placed in a foster home, old enough to participate in the adult O.T. program, or well enough and of age to be given a work assignment. Only a few children have not responded to the program: a post-encephalitic, a severely mentally retarded child with psychosis, and an 18-year old regressed schizophrenic.

Two employees are assigned to the program, one to take charge of the teaching, the other to direct arts and crafts, with both planning jointly all other activities. Members of the medical, psychology, social service, theological and nursing staffs visit frequently.

A volunteer, who is an educational psychologist, spends one afternoon a week with the children throughout the school year. During the winter months, teacher-volunteers from the local branch of the Association for Childhood Education* bring additional activities to the S.O.R.T. room: movies, slides, active games, music and discussions. A summer student with a teaching certificate proved to be a valuable addition during the summer. Supervision is provided by the registered occupational therapist in charge.

An S.O.R.T. Unit worker pauses in the midst of mixing finger paints to admire the building-block structure being shown to her by one of the young patients. Her genuine interest in his achievement typifies the rapport which prevails between the staff and patients in this unit.

Warm Rapport Established

The workers in this unit have a sincere interest in the children and are able to establish an atmosphere of "guided permissiveness." This is achieved through an attitude of kindness but firmness, understanding that flexibility and consistency are equally necessary in dealing with children. There is a genuinely warm relationship between the occupational therapy aides and the young patients which features healthy give-and-take resembling that of a good home situation.

Since backgrounds, diagnoses, stages of illness and mental endowments vary a great deal, it is not easy to find "common ground" on which mentally ill children can meet. Yet, since they have had a place of their own, there has been a great deal more "esprit de corps" among these young patients.

Academic work is still very much on an individual level, although several of the older children participate

**Ed. note: Hospitals which are interested in arranging for similar volunteer assistance with child patients should contact the A.C.E. branch in their locality to see whether the members (most of whom are elementary-school teachers) can undertake such a project. If information on whom to contact is not available locally, write: The Association for Childhood Education International, 1200 15th Street N. W., Washington 6, D. C.*

in discussions on health, social studies, history and such. Textbooks are purchased through hospital funds or borrowed from the Elgin public school system, as are the work books. A set of seventeen maps on a tripod was ordered and a green chalk board extends along one wall and half of the length of another.

Creative Group Activity

Out of doors there is a great deal of group activity, such as baseball, volley ball, running games, and playing on the playground equipment. On rainy days, the children play such games as "Monopoly", "Clue", "Scrabble", "Sorry", and others. They also enjoy slides, shown with the Viewmaster, and music selected for their particular level of interest. A rhythm band provides a good outlet for excess energy. Parties and picnics are considered an indispensable part of the program, as are trips to the Commissary, where the children can select their own purchases, visits to the hospital-laundry, the fire station, print shop, green house and the bakery.

During the arts and skills periods, the children are taught various crafts, from sewing to woodwork and from finger painting to oil painting. The young patients are encouraged to express themselves creatively, using clay, paints, such toys as "Farm" and "Circus", chenille pipe cleaners, leather, craftstrip, paper and beads. Other techniques, such as wood carving or metal tooling, are applied in accordance with the inclinations and capabilities of the patients. There is also a punching bag for outlet of aggression. The younger children have dolls, balls, trucks, fire engines, blocks, toy phones and coloring books, a wide selection of toys. Pistols and waterguns are used as "fantasy and aggression toys".

The adolescents have building sets, jigsaw puzzles, model kits, harmonicas, a typewriter and athletic equipment. A library of books and magazines is available to all youngsters. A play house was installed in the S.O.R.T. room, built large enough to allow 3 or 4 children to use it. It contains a small bench with a rug on it, so that some of the smallest patients can take a nap when they become too irritable.

Children's birthdays are observed with special activities and singing or record playing of the "Happy Birthday Song". Some of the children have reached the stage where they are planning their own activities. They have even asked about birthdays of employees who work with them so that they might arrange for a celebration.

Outdoor activities are an important part of the S.O.R.T. program when good weather permits, and playground equipment is provided for the purpose.

A sixteen year old high school girl has been assisting two afternoons a week during the summer months. She helped with all indoor and outdoor activities. A number of high school students from town have attended the picnics and parties given by the Association for Childhood Education chapter. In this way, contacts with non-institutionalized boys and girls are maintained, which gives the young patients an incentive for acceptable behavior through constructive activity. At the same time the arrangement provides the students from town with a better understanding of the problems of the hospitalized youngsters.

Since the children have had a Unit of their own, their attitudes and behavior have shown remarkable changes. Fighting among the youngsters has diminished, negativistic attitudes are easier to deal with, and actual learning has taken the place of much "aimless roaming."

The young patients are more amenable to therapy, more approachable with reasoning, better adjusted to each other, and, most important of all, they are happier children.

M. H. S. News & Notes

Dr. Blain Resumes Duties

The A.P.A. staff was pleased to welcome back Dr. Daniel Blain last month when, after being on leave of absence since September, he resumed his duties as Medical Director of the Association. During his absence these duties, including direction of M.H.S. affairs and the editorship of MENTAL HOSPITALS, were ably performed by Dr. Harvey J. Tompkins, who served as Acting Medical Director.

Program Committee Appointed for Seventh Mental Hospital Institute

Dr. Winfred Overholser, Chief Consultant to Mental Hospital Service, has named the following M.H.S. Consultants to serve as members of the Program Committee for the Seventh Mental Hospital Institute: Dr. Granville H. Jones, Superintendent of Eastern State Hospital, Williamsburg, Va.; Mr. R. Bruce Dunlap, Director of the Bureau of Institutional Management, Penna. Dept. of Welfare; and Dr. Gale H. Walker, Superintendent of the Polk (Pa.) State School. Dr. Harvey J. Tompkins is Chairman of the Committee.

As announced last month, the Institute will be held this year October 3-6 at the Sheraton Park Hotel in Washington, D. C.

Achievement Award Applications Due by March 15

Institutions which intend to apply for the 1955 Mental Hospital Service Achievement Awards are reminded that the closing date for receiving applications is March 15. No entries received after that date can be considered in this year's competition.

Because of the great task involved in judging the many applications submitted each year, it is important that applicants carefully follow the instructions enclosed in last month's issue of MENTAL HOSPITALS. Extra copies of these instructions are available upon request from Mental Hospital Service.

As in previous years, Award winners will be announced at the A.P.A. Annual Meeting in May.

THE GOVERNORS MEAN BUSINESS

Excerpts from some of the Governors' Messages to their Legislatures at the opening of the 1955 sessions

"It is obvious that the problem of our overcrowded mental, correctional and juvenile facilities is so vast that we cannot possibly catch up with it by building only out of surplus. To do so will mean simply that we will continue to lose ground.

"I therefore recommend that the problem be submitted to the voters of Ohio for a decision. In order to get this vital program under way as soon as possible, I recommend that $25,000,000 be appropriated from the anticipated surplus and a $115,000,000 bond issue be submitted to the voters for approval at the November 1955 election."

Governor Frank J. Lausche, Ohio

"There has been a marked improvement in the operation of our institutions under the Board of Control. A larger proportion of those treated in the State hospitals are returned to normal, useful lives. These encouraging results have come about, first, because the legislature has supplied increased appropriations needed for improvements in housing, equipment and care; second, because more and better doctors, more nurses and attendants have been provided; third, because a united effort has been made through a definite program of rehabilitation. The Board of Control, together with the legislature, should be commended. However, there is much yet to do."

Governor Leo A. Hoegh, Iowa

"Missouri laws should be amended to broaden the access of the mentally ill to hospital facilities for voluntary or observational admissions, to provide for possible reciprocal agreements with other states for the interstate transportation of the mentally ill and for proper inspections of the state hospitals by recognized authorities on the treatment of the mentally ill.

"I also recommend that State Hospital No. 1 at Fulton be established as a teaching and training hospital for psychiatrists, nurses and other professional personnel to cooperate with and work in conjunction with the School of Medicine at the University of Missouri."

Governor Phil M. Donnelly, Missouri

"We must find some way of reducing this ever-increasing load (of mental illness). We must concentrate our energies on the prevention and cure of mental illness. We must place more emphasis on research and training of skilled personnel.

"In the development of the Community Mental Health Services Program, adopted last year with bi-partisan support, we must find a new constructive approach to the whole problem of prevention. Many clinics should be established in local communities and others expanded and improved, so that incipient mental illness can be diagnosed and treated before it reaches the stage where hospitalization is required. Further, in the prevention of mental illness, we should materially increase the role of community hospitals, through both in-patient and out-patient clinics.

"The dramatic successes of research in physical medicine have not yet been duplicated in the mental illness field, but they point the way. Intensive research is essential if the terrible scourge of mental illness is to be brought under control. Although money is fundamental in research, we must also be able to attract the right kind of personnel.

"This brings me to the subject of the $350,000,000 bond issue which the voters of the State have just approved. The way in which these funds are used can mean relative success or failure in this field for generations to come. We must establish our new facilities in metropolitan areas and make them as small and non-institutional as possible, which will permit not only the best treatment but also easy contact with the outside world, both for patients and staff. In this way, we can make it easier to attract and hold the kind of personnel that is so badly needed if patients are to be cured and returned to normal lives. Also, we can increase the participation of distinguished psychiatrists in teaching, training and consultation, and can more readily stimulate volunteer activities on the part of a responsible citizenry to make the patients feel part of the community. Moreover, it will be possible to treat more people on an out-patient basis and, for those who have been cured through hospitalization, to ease the process of readjustment to normal lives after release."

Governor Averell Harriman, New York

"During recent weeks I have been preparing myself for the duties which I today assume. Included in these preparations have been visits to our State institutions. Such visits are a grim reminder of the great responsibility we have to provide adequate care and rehabilitation for so many less fortunate than ourselves. Such visits, on the other hand, disclose a high level of custodial care and plant maintenance in which we can take pride. While some institutions are overcrowded, others have idle space. I believe every consideration should be given to full utilization of existing facilities when we act on the overall housing problem with which we are confronted."

Governor Lane Dwinell, New Hampshire

"In the field of health, the major remaining problem is mental illness. It is my belief that the present program in Indiana of cure instead of custody has proved outstandingly successful. We have increased our mental hospital dismissals by over 650 in the past year; and, should this program receive further financial assistance, it can reach far greater heights. I recommend that sufficient monies be appropriated to insure adequate and comfortable housing, and, what is equally or more important, facilities for the treatment of patients, the principal requirement of which is adequate and properly trained personnel."

Governor George N. Craig, Indiana

"During this administration great strides have been made in public health and in mental health, particularly the latter. We have risen from the lower ranks in the category of states to a very high position, and the development of this field is yet in its infancy. I urge you, from an economic, a social and a humanitarian point of view, under no circumstances to neglect or hamper this great work, and if there is any place that I could sincerely recommend a more lavish expenditure than presently being made, I would pick this department."

Governor Raymond Gary, Oklahoma

". . . We have learned that a truly humane and effective program for treating this problem should not emphasize confinement and institutionalization, but prevention and rehabilitation. Experts tell us that if the mentally disturbed could be given treatment soon enough, many of them would never need institutionalization at all. . . . Thus it seems clear that the first principle on which a sound welfare program must be based is that its emphasis should be placed on prevention and rehabilitation, both because such a program is less costly and because it is more humane."

Governor Orville L. Freeman, Minnesota.

"Great progress has been made in the past biennium in improving the facilities and adding to the technical personnel needed in an improved mental health program. For the most part as yet, it is concentrated at the State Hospital at Jamestown. . . . Still with what has been done, an even greater amount must be done to make the State Hospital a fit place for our mentally ill. . . . Briefly, changes in trained personnel at the hospital have been pronounced. It now has eight psychiatrically trained and experienced doctors plus one medic trained in internal medicine and surgery. The nursing staff has increased from three to seventeen, the attendants staff from one hundred and ninety to two hundred and seventy-five. By 1956 two hundred students per year will be given psychiatric training instead of, as at present, about twenty."

Governor C. Norman Brunsdale, North Dakota.

"This year two new buildings at our State Hospital will be ready for use. One will provide specialized care for three hundred and sixty patients who are aged and mentally ill. The other . . . will provide intensive treatment for one hundred and fifty more patients whose illness is such as to offer hope that modern therapy can lead to early recovery. In this, as in our entire welfare program, the emphasis is on returning the individual to normal community life as soon as possible.

"During the past year, I authorized one hundred and twenty-five new positions at the State Hospital, most of which have been filled. This additional personnel is giving patients the immediate benefit of improved treatment. . . .

"Prevention, where possible, is both cheaper and better than cure. Our community mental hygiene clinics have expanded their operations. . . .

"To provide more effective cooperation among the various public and private agencies concerned with mental health, I have recently appointed a Co-ordinating Committee, assisted by a full time, highly qualified expert. . . . A demonstration clinic is being established in the Newport General Hospital. New buildings at the Rhode Island Hospital are to include facilities for the care of mental patients. Extension of service to mental patients at the Charles V. Chapin Hospital is being explored. The Co-ordinating Committee is working out a cooperative program of continuing advanced training to develop the highest possible competence in our professional personnel."

Governor Dennis J. Roberts, Rhode Island

"One of the most massive and heartrending problems we face is the proper care and treatment of the mentally ill or retarded. . . .

"There are 688 more full-time employees in the Illinois Department of Public Welfare than in January 1953. These are primarily in the area of care and treatment of patients. . . .

"As in all states, there is a dearth of professional and skilled personnel. While at present we have the greatest number of physicians in the State's history in the Department of Public Welfare, much effort is and will be expended in training our own staff. . . .

"Seventy-seven percent of the department's employees are certified through civil service, a new high. Nearly one hundred percent of those in the area of patient care are now under civil service.

"A forty-hour week has been provided in approximately one-half of the department's twenty-five institutions. This has been made possible by efficient administration without an increase in the State appropriation.

"The need for more knowledge in the causes of mental disease and mental retardation, the early recognition of these conditions, the intensive application of present knowledge and the close, continuing supervision of released patients are receiving all-out attention.

"Approximately one thousand Illinois citizens are volunteering their assistance to patients in our eleven mental hospitals and two schools for the mentally retarded. I should like to salute these volunteers for the immeasurable contribution they are making."

(The Governor spoke at length upon the proposed psychiatric training and research hospital, the State's nursing affiliate programs, and the improved feeding and housing of patients.)

Governor William G. Stratton, Illinois

"Through medical science and a greater awareness of the problem by the general public, real progress is being made in the care, treatment and rehabilitation of those suffering from mental illness. Specific mention should be given to our state mental health authority, Dr. M. A. Tarumianz, who has served the State of Delaware for over a third of a century with great ability as an administrator and with national distinction as a psychiatrist. Under his leadership Delaware has acquired an outstanding reputation in the mental health field. To the best of our ability we should continue to provide for the support which will enable Delaware to improve its program and facilities for the prevention and treatment of mental illness."

Governor J. Caleb Boggs, Delaware

Psychiatric Medical Records Present Complex Problems

By CATHERINE M. MORTON, R.R.L.
St. Louis State Hospital, Mo.

Those of us who work in mental hospitals often feel that because we do not know what is being done in other special hospitals, we as individuals cannot tell if our own operation in any way approaches the ideal. Other than the 1952 A.P.A. Diagnostic and Statistical Manual there is, so far as I can learn, but little information available on the keeping of records in mental hospitals.

In what information is to be had the emphasis has seemingly been placed on statistics rather than on record content—and this latter is surely the important thing. We read complex procedure outlines compiled by states with a central statistical agency and we read of elaborate punch card systems that some hospitals have set up. But when a medical record librarian at a new mental hospital visited me recently, she said that the only practical information she could find on keeping records in a mental hospital was in an article I had written for HOSPITAL PROGRESS in December 1951, and this she had used as a guide in setting up her department.

Keeping Records Alive

Ours is a 3,400 bed teaching hospital and many diverse research projects are the order of the day. This research is for the most part on inpatients and this at once raises the problem of keeping alive the records of long-stay patients.

This is little doubt but that the Rules and Regulations governing the resident staff of any special hospital require that notes be written at more or less regular intervals on long-stay patients. However, without the help of the record department a resident attending several hundred patients on a rotating service can hardly be expected to know, without spending many hours studying the records, when a progress note should be written on any patient. Moreover, a doctor may not have occasion to see some of his long-stay patients unless an appointment is made. Patients employed in a hospital industry, on a work detail or on an open ward may at no time during a particular doctor's period of service be on the ward when daily rounds are made. If he is provided with a list, however, of those on whom a note should be written, the doctor need only tell the supervisor to hold those patients on the ward the morning he chooses to see them.

The following account of the method we use to keep track of long-stay patients is elementary in content, but has proved its worth many times over. Prior to its adoption it was relatively easy to lose track of, say, a mental patient with a cardiac condition. But with the information on somatic conditions stamped on the patient's identification card, the doctor has something in the way of needed information about each patient when he is rotated to new divisions. The importance of having knowledge of previous as well as current medication and dietary needs readily at hand needs no stressing.

When the 1952 Diagnostic and Statistical Manual was published, we set up in the medical record department a completely new statistical file of the resident population with full neuropsychiatric diagnostic breakdown in accordance with the revised nomenclature for admission status, sex and color on cards identical with that shown in the manual. This was done to facilitate compilation of statistical reports as required on inpatients and to establish the use of the improved card form. This permitted conversion of the index we had been using to one designed for progress note control. The cards of the old index were separated according to hospital divisions, medical records were checked for date of last progress note and this was pencilled on the cards.

Lists were then prepared according to divisions, showing case number, name, and date of the last notation. The lists were distributed to the medical staff by the clinical director with the request that past-due progress notes be brought up to date. This was done, and on a given date all records contained a current report. A simple form was designed and kept in the record department for the recording, by the physician, of the patient's name, hospital division and date of later progress notes. As these notes are recorded the data is transferred by department personnel to the indicated card.

Status Easily Checked

To determine the progress note status of a selected group or of all patients is then a simple matter and can be done in a short period of time. It should be noted that physicians are not required to list notes written on charts which are kept on the receiving divisions; these are checked when the chart is received in the record department at time of transferring the patient to a regular ward.

This file also provides for the resident physician, as he is rotated from one division to another, a ward by ward index (in the record department) of his current patients together with the neuropsychiatric diagnosis, admission date, age, religion, degree of education, I.Q., and any type of special therapies (including psychosurgery) that may have been administered. In addition, it serves in the selection of cases for special studies by various departments. Access to the index is quick and easy as it is housed in a wheel file.

The content of the Identification Card, as filed on each division and which accompanies the patient at all times, is very important. In addition to identification data there is also recorded the reason for transfers from one division to another, current medication, whether the patient has a heart condition, diabetes, history of tuberculosis, is subject to seizures or is penicillin-sensitive. The information with

reference to somatic conditions is stamped on the card while the patient is in a receiving division or hospitalized in one of the general (acute) hospital divisions.

General Hospital Records Differ

I would like to add a word about how the keeping of medical records in a mental hospital differs from keeping them in a general hospital. General hospital patients seldom stay more than a few days, while some mental hospital patients may stay several months or even years. These prolonged periods of hospitalization require of course that the medical record librarian keep alive the records of these patients by recording progress notes at reasonable intervals, and to see that the records themselves are kept presentable and that face sheet information is reliable over these long periods.

Inasmuch as most neuropsychiatric research has to do with in-patients, special therapy indices must be kept. Such indices are foreign to a general hospital record department. While the rules and regulations of special hospitals require that admission notes, physical and neuropsychiatric examinations and all special laboratory examinations be recorded within a specified period of time, it becomes the duty of the medical record librarian to keep work sheets showing the status quo of required work-ups, and urging completion in case of unwarranted delay. It is chiefly in the analysis of intramural hospital charts that the records work in a special hospital resembles that of a general hospital.

Information Wanted

I would like to know how record problems are met elsewhere. What, for instance, do other mental hospitals do with 25- or 30-year old bedside records? How long are the original records kept intact? Have record summaries been tried and proved of value?

Such information would be helpful, not only to the medical record librarians, but to the administrators and medical staffs also. Regular information in the columns of this magazine might do something towards building up deplorably under-staffed medical record departments.

PROFESSIONAL CONFERENCES

Joint Commission Proposed to Formulate Future Needs

The establishment of a Joint Commission on Mental Health and Illness was proposed by the American Psychiatric Association and the Council on Mental Health of the American Medical Association, at a meeting in Washington on January 7th and 8th.

The Commission would have two major objectives:

1. To make a national survey of all aspects of the present status of our resources and methods of diagnosing, treating and caring for the mentally ill and retarded, both within and outside of institutions, and for promoting mental health.

2. To formulate, on the basis of this survey, a feasible program for the fundamental improvement of our methods and facilities for the diagnosis, treatment and care of the mentally ill and retarded, and for the promotion of mental health.

It is evident to professional groups whose major concern is psychiatry that such a survey and evaluation is urgently needed, since we are without a comprehensive, up-to-date, integrated body of knowledge, in spite of the many worthwhile surveys and studies already made. Without such knowledge, present and future directions of progress cannot be adequately planned.

Underlying the proposal is the thought that such a project might lead to some fundamental departures from our traditional concepts and methods of dealing with mental illness, thus leading to more effectual methods than have yet been developed.

The broad support of all major organizations concerned with the problems of mental illness and health would be needed. Fifteen of these organizations are being invited to take part as co-sponsors, and have been requested to send representatives to a small Planning Committee early in the spring.

The Planning Committee would carry out the early stages of the work under a grant from the Field Foundation, and it is anticipated that the several hundred thousand dollars which would be needed for the total project could be obtained from foundations and other sources quickly following the planning stage.

A.P.A.-A.H.A. Committee to Study Psychiatric Needs of General Hospitals

A joint American Psychiatric Association and American Hospital Association Committee has been established by the two associations. The purpose of the committee is to explore means by which the two associations can provide assistance for the improvement and numerical increase of psychiatric services in general hospitals. There is a possibility that a research study of the function and design of existing units may be sponsored by the joint committee. The first meeting of the committee will be held shortly.

The A.P.A. representatives, appointed by the President, Dr. Arthur P. Noyes, are Dr. Charles Bush, Director of the Architectural Study Project, as Chairman; Dr. Paul Haun, Bowman Gray School of Medicine, Winston-Salem, N. C.; Dr. Alfred H. Stanton, VA Hospital, Boston, Mass.; Dr. Ralph M. Chambers, Chief Inspector, Central Inspection Board, and Dr. Harvey J. Tompkins, Chief, VA Psychiatry and Neurology. The A.H.A. members are the Reverend Hector L. Bertrand, S.J., Comité des Hôspitaux du Québec, Outremont, Montreal, and Dr. Morris H. Kreeger, Michael Reese Hospital, Chicago.

The establishment of the joint committee is the outcome of much preliminary work between A.H.A. representatives and members of the staff and consulting group of the Architectural Study Project.

The Council of the A.P.A. in its resolution passed on October 30th, 1954, expressed the hope that "the joint committee will explore the urgent need for the establishment of more psychiatric units in general hospitals, and that consideration will be given to the possibility of joint sponsorship of a research study of the design and function of existing units in general hospitals."

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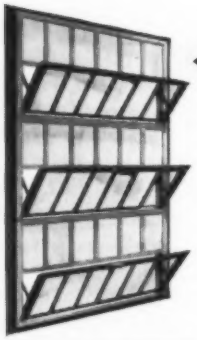

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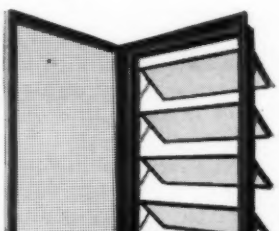

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Particularly applicable to the needs of mental hospitals. Awning type design with 100% ventilation. Degree of opening of simultaneously operated vents is controlled with small removable crank, permitting operation by authorized attendant only. Principal restriction against injury or escape of patient is provided by detention screen opened only by removable key, also carried by attendant.

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Suitable for use in mental institutions where moderate restraint will suffice. Awning type, with 100% ventilation as standard. Available in single, double or triple designs, built integral and controlled with a single operating handle. Size of vents and degree of opening may be designed to meet any requirement. For rooms housing violent patients, restraint and protection from injury may be further provided by detention screens.

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ARCHITECTURAL STUDY

Basic Studies Initiated by Architectural Group

The admission data and record of treatment on approximately 10,000 patients admitted to ten selected mental hospitals during 1953 are being tabulated for study by new research teams, organized by the Architectural Study Project.

"The factual information that this study will uncover will be the basis for future programming and planning by the Study Project," says Dr. Charles K. Bush, the Director. He also indicated that existing statistics on various activities taking place in the state institutions will be welcomed by the Study Project to supplement its own information.

There has been no previous research of similar scope on patient classifications and treatment programs, without which programming for architectural planning is very difficult. The basic information to be collected and tabulated includes the diagnosis on admission in accordance with the nomenclature established by the American Psychiatric Association Diagnostic and Statistical Manual, 1952; the behavior characteristics of each patient on admission and at a later date; the types and amount of treatment given; the length of time each patient spent on the Receiving Service and whether he was transferred to another Service, such as Continued Treatment, or whether he was released; and the final status of each patient as of the date of the current study.

The study started on January 12th at Stockton (Calif.) State Hospital and is expected to take from 3 to 4 months. The researchers will send periodical reports to Washington so that the material can be processed as the study progresses.

Other institutions which are being surveyed at the same time are: Manteno (Ill.) State Hospital; Fairfield (Conn.) State Hospital; Southeast Louisiana State Hospital, Mandeville; Norristown (Pa.) State Hospital; Spring Grove (Md.) State Hospital; Gailor Psychiatric Hospital, Memphis, Tenn.; Woodside Receiving Hospital, Youngstown, Ohio, and the Day Hospital sections of the Menninger Clinic, Topeka, Kansas, and of the Allan Memorial Institute, Montreal, Canada.

These hospitals were selected because their general geographic location will provide a cross-section sampling and because each hospital has a reasonably new receiving facility which, it is assumed, will more effectively assist staff members in carrying out the therapeutic program of the unit.

The calendar year 1953 was selected to ensure complete information on the approximately 10,000 admissions to all ten hospitals, and at the same time to provide the most recent factual data possible.

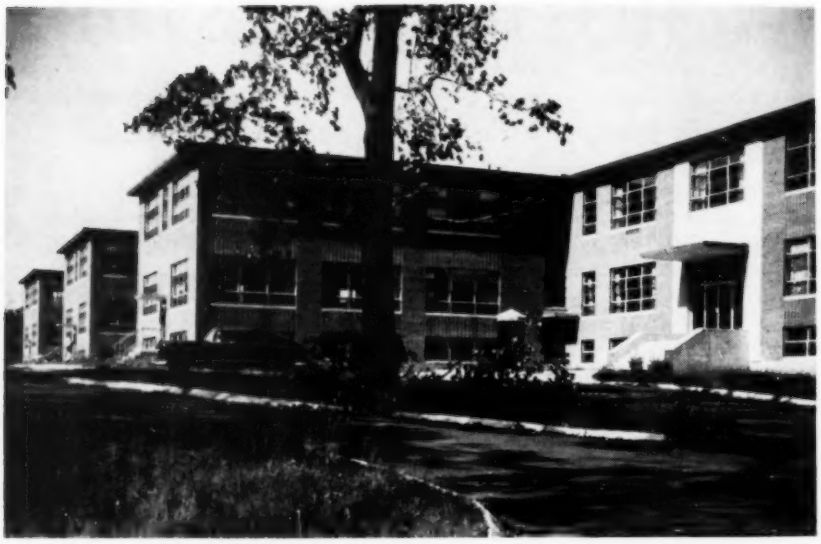
The studies will be conducted by psychiatric social workers and psychologists who will reside at the hospital during the period of the study. These disciplines were selected because they would be acceptable to the hospitals and have had sufficient experience in psychiatry to understand the records and be able to extract the necessary information. Mrs. Rose C. Thomas of Washington, D. C., a psychiatric social worker, is coordinating the research teams for the study, and has assisted Dr. Bush in the difficult task of obtaining professional personnel for this relatively short period. Dr. Bush is accompanying the research workers to their respective assignments to orient them and to insure correct tabulating procedures.

After the initial study is well under way, a second phase will be initiated. This second study will consist of actual observation of the receiving unit by an architect—not the architect who designed it. In cooperation with the Project's social worker and hospital staff members, he will carefully review the physical facilities, materials and equipment. Future studies will be concerned with an analysis of hospital functions, practices and procedures.

However effective modern treatment techniques may be, they can be still more effective if their physical needs are met by sound architectural arrangements. The Architectural Study Project staff feels that the information now being sought can become a factual base from which may be determined the most feasible building sizes, what facilities should be planned, the type of problem which arises from particular types of construction and many other problems.

With more basic data available to assist those who will be planning new construction during the next 10 years, the millions of dollars which will be spent can probably be used to better advantage. The basic information gained by this initial study of mental hospital admissions should serve too as a foundation for further, more extensive investigations into related architectural needs in the future.

Floor Plans for the Walter E. Fernald State School Unit for the Blind Retarded



Herewith we present the floor plans for the Ransom A. Greene building for the blind mentally deficient at the Fernald State School, Waverley, Massachusetts, which was described in the December, 1954, issue.

There are several interesting features in this building in addition to the extensive use of glass to obtain as much daylight as possible for those patients who still retain light perception. Dormitories are broken up by stub walls, which prevents, to a certain extent, overcrowding, and makes it easier for the blind person to find his individual bed. Sharp edges and corners were not eliminated, because it was felt that the blind person should learn that these things exist in the outside world in case of his return to the community.

The "progressive" showers which are located on each floor consist of a maze through which the patient moves by holding to a railing on the wall. The temperature of the water in the showers, which are set at regular intervals along the wall, varies from warm at the start to cool at the end, so that patients tend to move on as they get near the end of the maze. Patients are undressed in an anteroom, and shortly after they enter the shower, soap is applied by an employee who is clad in a bathing suit. As they leave the shower an employee dries them and they enter another anteroom where they are dressed in clean clothes. Shower controls are on a raised platform at the end of the room from which an employee can see the entire shower area.

The swimming pool in the basement under the gymnasium is used by all patients of the institution, and a definite effort is made to teach as many patients as possible to swim. The floor slopes upward toward the pool edge to warn the blind patient that he is near the water. Above the swimming pool is the gymnasium, which makes an excellent play space for the children in addition to its use for basketball and other events.

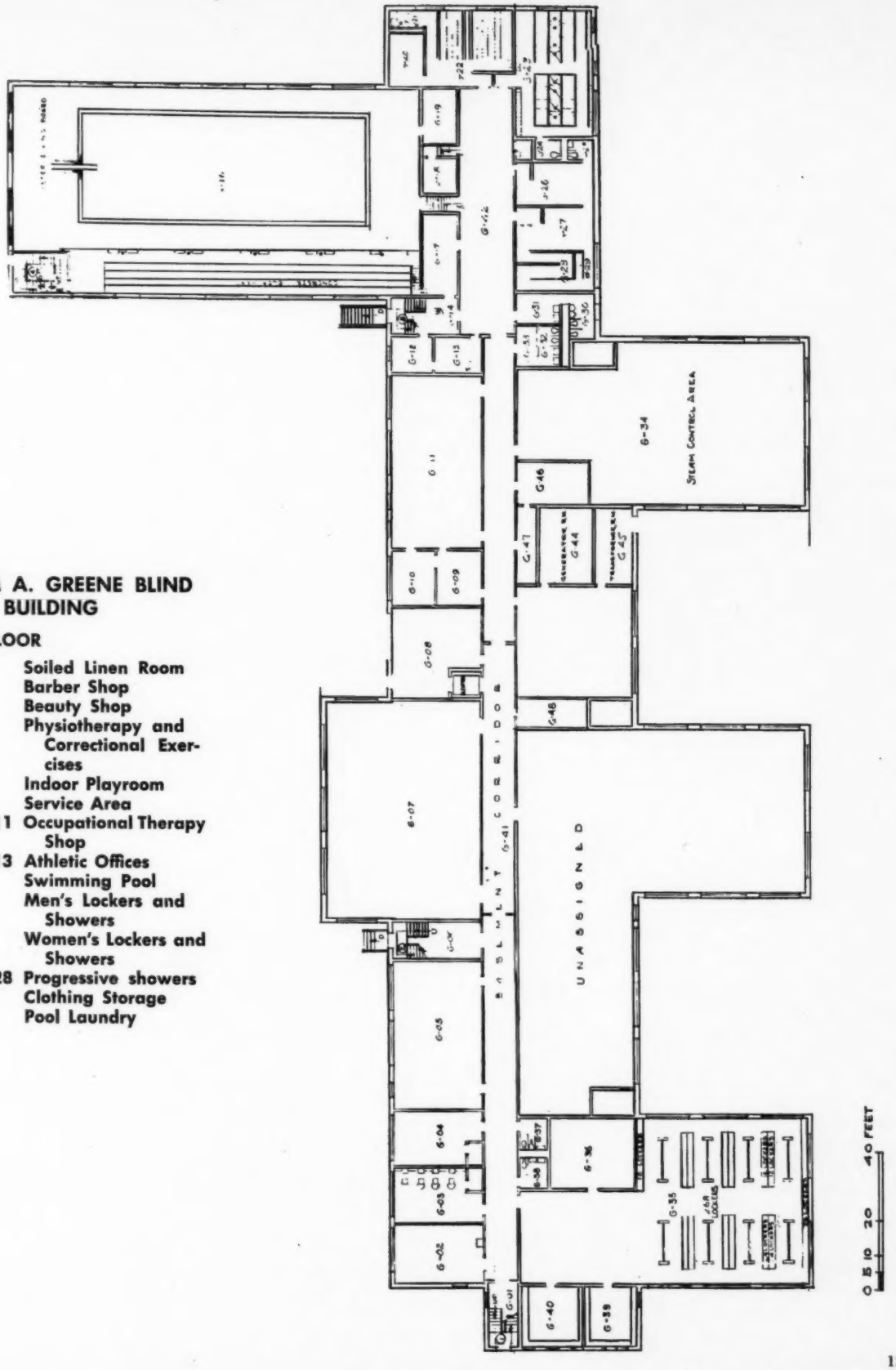
Each ward has a door opening to the outside where there are both open and fenced-in play areas. Occupational therapy rooms and academic classrooms are an integral part of the building and braille is taught to those with sufficient intelligence to master it.

The predominant feature of the program in this building is activity which attempts to bring out the maximum abilities of the blind retarded child. Many of them are expected to become self-supporting and cease to be public charges.

RANSOM A. GREENE BLIND BUILDING

GROUND FLOOR

G-02	Soiled Linen Room
G-03	Barber Shop
G-04	Beauty Shop
G-05	Physiotherapy and Correctional Exercises
G-07	Indoor Playroom
G-08	Service Area
G-09 to G-11	Occupational Therapy Shop
G-12 & G-13	Athletic Offices
G-16	Swimming Pool
G-22	Men's Lockers and Showers
G-23	Women's Lockers and Showers
G-26 to G-28	Progressive showers
G-35	Clothing Storage
G-46	Pool Laundry



RANSOM A. GREENE BLIND BUILDING

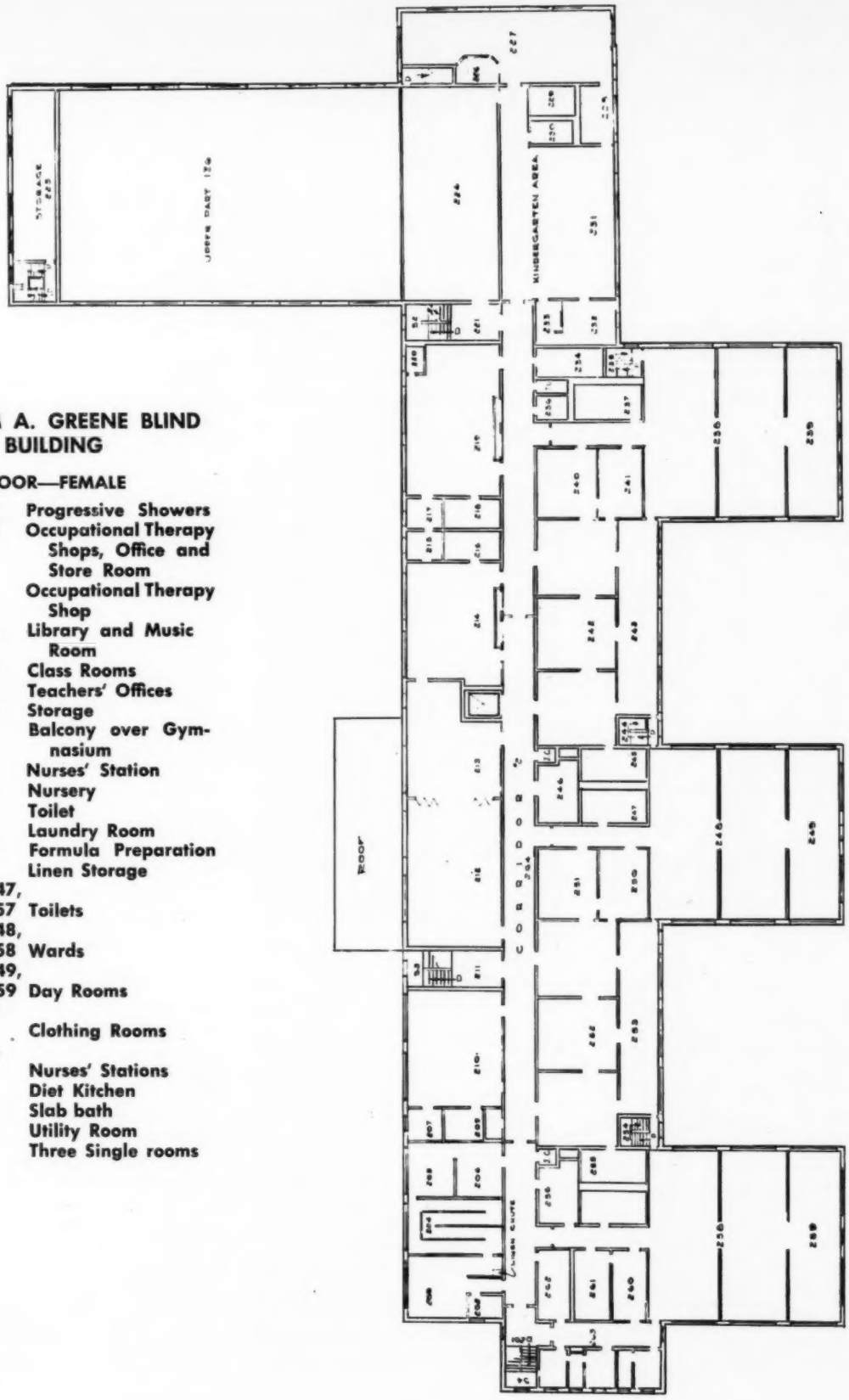
FIRST FLOOR—MALE

102 to 106	Progressive Showers
107 & 108	Occupational Therapy Shop, Office and Store Room
110	Occupational Therapy Shop
112	Cafeteria
113	Serving Area
114	Dish Room
115 to 120	Class Rooms
117 & 118	Teachers' Offices
116 to 119	Storage
121	Ophthalmologist's Office
125	Storage
126	Gymnasium
128	Interviewing and Individual Therapy Room
132	Visitors' Room and Group Therapy
133	Psychiatrist's Office
134	Supervisor's Office
136	Receptionist
137	Treatment Room
140	Linen Storage
145, 156, & 166	Clothing Rooms
146, 155, & 165	Nurses' Stations
142, 150, 152, 160, & 162	Toilets
143, 147, 153, 157, & 163	Wards
144, 148, 154, 158, & 164	Day Rooms
151	Diet Kitchen
161	Slab bath
168	Three Single rooms

RANSOM A. GREENE BLIND BUILDING

SECOND FLOOR—FEMALE

202 to 106	Progressive Showers
207 & 208	Occupational Therapy Shops, Office and Store Room
210	Occupational Therapy Shop
212 & 213	Library and Music Room
214 to 219	Class Rooms
215 & 217	Teachers' Offices
216 & 218	Storage
224	Balcony over Gymnasium
226	Nurses' Station
227	Nursery
228	Toilet
229	Laundry Room
232 & 233	Formula Preparation
234	Linen Storage
237, 245, 247, 255, & 257	Toilets
238, 242, 248, 252, & 258	Wards
239, 243, 249, 253, & 259	Day Rooms
240, 251 & 261	Clothing Rooms
241, 250, & 260	Nurses' Stations
246	Diet Kitchen
256	Slab bath
262	Utility Room
263	Three Single rooms



"Institutionalitis"

It is a condition found in staff, relatives and the community that slows rehabilitation

By LILLIAN L. COLE
Director of Psychiatric Social Service
N. J. Neuro-Psychiatric Institute, Skillman

"Institutionalitis" is not of medical or psychiatric nomenclature. It cannot be found listed in professional dictionaries nor mentioned in scientific manuals. Although not a technical term, it is descriptive of a condition which should be the cause for much concern. Unless treatment and preventive measures are utilized, this condition can be a serious handicap in rehabilitation. The problem is complicated still further as it is not confined within the walls of an institution but permeates homes and communities.

This "disease" warps the personality, creates apathy, encourages dependency and overpowers any initiative in patients. It stifles the institutional staff, divorces patients from their families and ostracizes them in their communities.

Much attention has been given to the various therapies as a means of helping patients. Recently Dr. Maxwell Jones developed the use of therapies still further and, as related in his book, *"The Therapeutic Community,"* stresses the importance of a whole institutional culture which would foster healthy personalities. Under this plan therapy covers the entire day of the patient and includes all his contacts with other persons, such as would be found in the normal interaction of healthy community life.

Whatever therapies are used are focused to help a patient with his problems—problems which led to his commitment to the institution. Indirectly, these therapies also combat the development of "institutionalitis," as a patient involved in treatment is less apt to develop symptoms.

Unfortunately "institutionalitis" is not confined to the patient. Forms of this "disease" infect the institutional staff, the relatives of the patient and his home community. Treatment of such cases is more difficult and often completely neglected. Keeping in mind the objective of rehabilitation, spread of this should be prevented.

Symptoms in the Staff

Just as familiar objects are taken for granted and not particularly noticed until missed, patients, who have lived in the institutional community for years, become so much a part of the place that they get lost in the group and remain year after year.

In the reorganization of the State Village for Epileptics (now the N. J. Neuro-Psychiatric Institute) every patient was re-evaluated. During this process patients were "found" who had been seizure-free for many years and perfectly capable of returning home and yet had remained a continuing burden upon the state. Must re-organization be necessary to find the lost or forgotten? Less drastic would be the treatment of "staff blindness," a symptom of "institutionalitis."

Another symptom is staff obsession which makes it impossible for a patient once labeled ever to change that label. For example, years ago a patient may have been known as a troublemaker. A troublemaker he remains in spite of years of model behavior.

Lack of staff understanding and confidence can also be considered symptoms. These appear after staff blindness and obsession have been overcome and a patient is, after years of confinement, ready to go home. He has been prepared for the move and is looking forward to really living, only to be told by some staff member, "You will be back soon. You have been here too long to be able to adjust outside." At a time when understanding, support and encouragement are needed and the patient, although eagerly anticipating the move, is full of his own fears, anxieties and doubts about his ability to adjust, such expressions by others only serve to make his burden heavier.

In-service training programs go far in helping cure staff "institutionalitis." Many institutions have such programs but they are often available only to the professional staff. In line with Dr. Jones' stress upon the important treatment role of the whole institutional culture, in-service training should be compulsory for every employee who comes in contact with patients.

Family Reactions Affected

"Institutionalitis" also develops in the patient's home. Commitment of a member of the family, regardless of the reason, is seldom easy. For quite some time the patient's absence is felt and the varied emotions aroused as a result of this move have to be handled. Then, as time passes, the family becomes accustomed to the absence. The vacant chair and the empty bed become customary or are occupied by another. There may be a scar, but the wound heals. Even visiting the patient may become less frequent as the daily routine of life absorbs the family and moves on without the patient. In this way families may be said to have "institutionalitis."

Any talk of having the patient return home is traumatic. Memories of the heartaches, the anxieties and prob-

Ed. note: Miss Cole's article, which is reprinted here through the courtesy of the *Welfare Reporter*, published by the New Jersey Department of Institutions and Agencies, received the $100 first prize in the Board of Managers annual award last year.

lems which led up to the commitment are revived. If a patient does go home it may be to an environment which lacks understanding, is over-protective, fearful, suspicious or even hostile. In some instances families refuse to accept the patient saying, "He was legally committed, so he is your responsibility, not ours."

Family reactions are often due to or intensified by "institutionalitis." Social workers, in pre-placement planning and follow-up care, are making every effort to "cure" families of this "disease" as they help the patient and his family make the adjustments. Needless to say, this is a slow process, time-consuming and often discouraging. Such families frequently need so much help themselves they are unable to help the patient and his return to the institution becomes necessary.

A preventive program with families would be the ideal, but institutional budgets seldom allow for an adequate staff to make this possible. In the ideal situation, families would be required to take part in the treatment program, having regular interviews with the social worker throughout the patient's hospitalization. They would be helped to understand the patient's experiences and progress in treatment, to be aware of the changes taking place in the patient, and to gain a better understanding of themselves and their inter-personal relationship with him. From the time of admission, the main focus of the interviews would be upon eventual discharge. Thus, the trauma of discharge is eliminated, families are ready to help the patient, the transition from the institution into the home is easier for everyone, and a good adjustment is a greater possibility.

Community Education a Cure

"Institutionalitis" in communities is evidenced by lack of understanding, fears and social ostracism. Newspaper headlines of murder, rape and other crimes committed by former patients of any institution add fuel to the fire and institutions are censured for "daring" to release patients. If the patient is obviously harmless even in the eyes of laymen, then the institution is criticized for "turning him out into the cold cruel world."

If families are helped to accept the patient, he must still cope with community feeling. A program of community education is an essential part of any institutional program and every member of the professional staff should have responsibility in this area. The burden of this, however, is not theirs alone. Every patient who returns to the community, whether it is to his family, to a job, or to a hospital family care home, and makes a good adjustment, is helping. Every understanding family, employer or hospital family care mother carries this understanding to their families, friends and acquaintances. Associations for mental health, epilepsy, and the like, also help in this vast problem of education. As communities learn, there is less "institutionalitis" and they join in helping rehabilitate the patient.

It is evident, then, from these illustrations that "institutionalitis" is not to be lightly regarded, because it involves more than just the patient himself. It is a condition that merits serious thought if plans for any rehabilitation program are to be successful.

DEPARTMENTS

Volunteers

VOLUNTEER STARTS SCRAP PROJECT FOR HOSPITALS

A display of articles made by patients in Minnesota State institutions held in St. Paul, the state capital, not long ago was the result of a project started by a St. Paul woman. The articles were made of fur, cork, aluminum, felt, and small machine parts—all scrap materials which had been contributed by industrial firms. The display was held so that staff workers from the state hospitals could get new ideas for their institutions.

The scrap-collecting project was begun seven years ago by Mrs. Dora Wilson of St. Paul, who was then chairman of the mental health committee of the Minnesota Federation of Women's Clubs. Upon learning that the state hospitals could use such materials, she began collecting the scraps from manufacturers and distributing them to the hospitals. The project grew until, in 1954, it was taken over by the volunteer services division of the Public Welfare department.

Since then the campaign for scrap materials has been conducted under the direction of Mrs. Miriam Karlins, State Volunteer Coordinator for the Minnesota Department of Public Welfare. Of Mrs. Wilson's effort, Mrs. Karlins recently said, "One woman started this project—thousands are now benefitting."

RECRUITMENT BROCHURES AVAILABLE FROM N.A.M.H.

An attractive little booklet, designed to interest citizens in giving volunteer service to mental hospitals, has been published by the National Association for Mental Health. The booklet, "Wanted—Your Magic", tells how and why volunteers can be helpful to the hospitalized mentally ill. It was originally published by the N. Y. State Society for Mental Health through a grant from the Doris Duke Foundation.

The 16-page brochure, conveniently sized to slip into a #10 envelope, costs ten cents a copy for quantities up to 100, $7.50 per hundred, and $50 per thousand. Requests and inquiries should be directed to the National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

Patients Select Footwear in Hospital Shoe "Store"

The shoe department of Larned (Kans.) State Hospital's clothing store allows patients the pleasure of being fitted in shoe styles of their own choice. The department is advised by the hospital's chiropodist, who confers regularly with the nurses and attendants regarding shoe-fitting and foot care.

Dietetics

EMPLOYEE CAFETERIA OFFERS VARIED BREAKFAST MENU

A recent innovation to brighten employees' breakfast at one Kentucky state hospital has been the offering of a varied breakfast menu comparable to that of most commercial cafeterias.

Each morning all varieties of cereals, in individual containers, and of fruit juices are displayed. Occasionally an assortment of dried fruits is added. At the grill, which was installed when the plan began, employees may choose eggs or hot cakes. In past years these two items alternated as the main fare offered, and only one type of cereal and juice or fruit was offered each day.

There are some additional costs in a program of this sort. The individual cereal containers cost slightly more than bulk quantities. Some cooking problems are entailed in the smaller amounts now prepared of any one item.

One problem envisioned, that of the person who would help himself to every item offered, has proved inconsiderable. The number of persons of this type among the 150 to 200 employees served by the cafeteria is so few as to make no significant difference in the total amount of food served, and so, to date, no restraint has been placed on the quantity of food an individual may take.

The plan has proved so successful with the hospital's employees that it is felt any extra costs or work involved are well justified.

FRANK M. GAINES, M.D.
Commissioner
Ky. Dept. Mental Health

People & Places

With the establishment of a Research Service, the Hillside Hospital of Glen Oaks, N. Y., announces the appointment of Dr. Maximilian Fink as Director of Research. Dr. Fink will direct studies on psychologic, neurophysiologic and biochemical aspects of mental illness. . . . In Illinois several new appointments have been made at Chicago State Hospital; Dr. Kalman Gyarfas has replaced Dr. Duncan D. Campbell as Superintendent, and Dr. John Cowen was named Assistant Superintendent (Medical.) Dr. W. M. C. Harrowes, previously in psychiatric and neurologic practice in Edinburgh, Scotland, has joined the staff as Director of Research and Education: . . . Illinois also announced the appointment of Dr. Abraham J. Simon as administrator of the new William Healy Residential School in Chicago. The school, which will study and treat 40-48 children with serious emotional disturbances, is an extension of the state's Juvenile Research Institute. . . . Dr. Ernest M. Gruenberg has resigned as executive director of the New York State Mental Health Commission to take part in directing the mental health activities of the Milbank Memorial Fund.

How to Order Loan Library Documents

M.H.S. Loan Library documents are available to our subscribers on two weeks' loan. Not more than three documents can be sent out at one time.

A flat charge is made for postage and handling of each document, according to the weights given after each listing—15¢ for a document weighing up to one pound, and 5¢ for each additional pound, *per document*. Thus a two-pound document would cost 20¢, a three-pound one 25¢ and so on. A few of the documents are more economically mailed first-class; these costs are listed accordingly. Please enclose the correct amount in postage stamps with your request.

Mental Hospital Service would welcome new documents to add to the library, especially procedure manuals and training outlines of all kinds. Six copies are needed in order to fill the many requests without undue delay.

LOAN LIBRARY CATALOGUE

WARD MANUALS AND TRAINING OUTLINES

Clinical Training Ward Teaching Program *(Manteno, Ill., State Hosp.)*	1 lb.
Clinical Pastoral Training *(St. Elizabeths Hosp., Washington, D.C.)*	2 lbs.
Clinical Psychology Training Programs in State Hospitals *(Illinois)*	1 lb.
Clinical Psychology Service Programs in State Hospitals *(Illinois)*	1 lb.
Educational Program for Psychiatric Aides *(Ill. Dept. Public Welfare)*	1 lb.
Lecture Outline in Psychiatry & Neurology *(Ypsilanti, Mich., State Hosp.)*	2 lbs.
Procedure Book for Neurologic Section *(VA Hosp., Hines, Ill.)*	3 lbs.
Physicians' Manual *(B.C. Psychiatric Services)*	2 lbs.
Residents' Manual *(Topeka, Kansas State Hosp.)*	2 lbs.
Nursing Procedures *(Provincial Mental Hosp., Ponoka, Alberta)*	2 lbs.
History and Curriculum, Menninger School for Psychiatric Aides	1 lb.
Outline of Training Program for Psychiatric Attendants *(St. Elizabeths Hosp., Washington, D.C.)*	1 lb.
Training Course for Supervisors & Selected Charge Attendants *(Spencer, W. Va., State Hosp.)*	1 lb.
Manual of Standard Procedures *(Conn. State Hospital, Middletown)*	1 lb.
Ward Policies Manual *(Topeka State Hospital)*	1 lb.
Ward Procedure Book *(Topeka State Hospital)*	2 lbs.
Ward Manual *(DeWitt, Calif., State Hosp.)*	2 lbs.
Ward Manual *(Norwalk, Calif., State Hosp.)*	2 lbs.
Ward Manual *(Patton, Calif., State Hosp.)*	3 lbs.

O.T., R.T., & ADJUNCTIVE THERAPIES

Occupational Therapy Training & Trends *(Ontario Hosp., Woodstock)*	1 lb.
Industrial Therapy Manual *(Topeka State Hosp.)*	2 lbs.

MEDICAL RECORDS & ADMINISTRATIVE PROCEDURES

Manual on Medical Records *(Calif., Ill., La.)*	5 lbs.
Punch Card Coding System *(Vermont State Hosp.)*	6¢
Organizational Charts *(various U. S. hospitals)*	1 lb.
Record Keeping Procedures *(Northern State Hosp., Washington)*	1 lb.
Summary of Personnel Practices for Salaried Employees *(Mayview, Pa., State Hosp.)*	1 lb.
Personnel Manual *(Ingleside Hospital, Cleveland)*	1 lb.
Rules and Regulations for Canteens and Stores *(California State Dept. Mental Hygiene)*	1 lb.

MENTAL DEFICIENCY

Mental Deficiency in New Jersey *(State of New Jersey)* A report to Gov. Robert B. Meyner and the Members of the Senate and General Assembly. 1954.	1 lb.
Mental Deficiency—A Vital Community Problem *(Report of the Medical Society of Delaware—1952)*	9¢

MISCELLANEOUS

Drug Formulary *(Arkansas State Hosp.)*	1 lb.
Education of the Public—A Function of the Public Psychiatric Hosp. *(Walter E. Barton, M. D.)*	6¢
Mental Hospital Publications for Personnel and for Public Information	2 lbs.
A General Plan for Expanding Michigan's Mental Hospital Facilities *(Mich. State Dept. Mental Health)*	1 lb.
Volunteer Participation in Psychiatric Hospital Services *(National Comm. for Mental Hygiene)*	1 lb.
Psychology Research Program *(Illinois)*	1 lb.
Vocational Rehabilitation in a State Mental Hospital *(N.I.M.H.)*	1 lb.

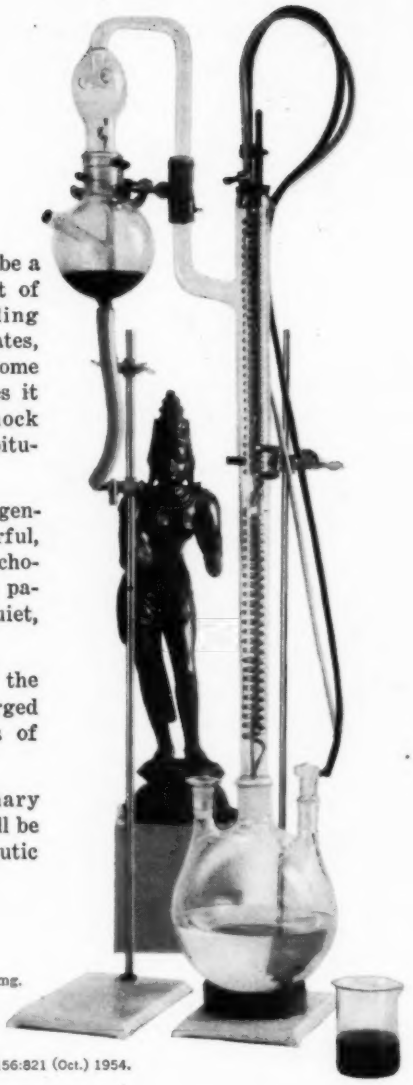
A NEW EMOTIONAL STABILIZER FOR NEUROPSYCHIATRIC THERAPY

Serpasil, in a recent study,[1] proved to be a valuable supplement in the treatment of neuropsychiatric conditions, including schizophrenia, paranoid and manic states, general paresis with psychosis and some cases of depression. In many instances it eliminated the need for electroshock therapy, restraints, seclusion and barbiturate sedation.

Combative, uncooperative patients in general became friendly, cooperative, cheerful, sociable and more amenable to psychotherapy under Serpasil. Hyperactive patients became sedate, noisy patients quiet, depressed patients alert.

Serpasil produced remissions in 20 of the 74 patients studied. Eight were discharged from the hospital. Long-term effects of treatment have not been determined.

If extended studies confirm preliminary findings, the authors state, Serpasil will be one of the most important therapeutic agents in the history of psychiatry.



Parenteral Solution (for psychiatric use only), 2.5 mg. Serpasil per ml., 2-ml. ampuls.
Tablets, 1.0 mg. (scored), 0.25 mg. (scored), 0.1 mg.
Elixir, 0.2 mg. Serpasil per 4-ml. teaspoonful.

1. Noce, R. H., Williams, D. B., and Rapaport, W.: J. A. M. A.: 156:821 (Oct.) 1954.

Serpasil®
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CIBA
SUMMIT, N. J.